EMS-251 (7/11)

Department of Community Health
EMS and Trauma Systems Section
P.O. Box 30437
Lansing, MI 48909
(517) 241-0179

VERIFICATION OF OUT-OF-STATE LICENSURE

Authority: Public Act 368 of 1978, as mended.

PART I – To be completed by the applicant and forwarded to the appropriate State Licensing Agency for completion.

Please indicate the level of licensure for which you are requesting verification:

☐ Medical First Responder ☐ Emergency Medical Technician ☐ EMT-Specialist/Intermediate 85 ☐ Paramedic

First Name	Middle Name	Last Name

All Previous Names and/or Birth Names Used (if applicable)	Date of Birth	Social Security Number

State Agency	License Number	Date of Issue

The applicant named above has applied for licensure in Michigan and has indicated licensure in your state. Please complete Part II of this form and return it to the address shown above. (**Must be received with original signature, faxed copies are not accepted**)

PART II – To be completed by the State Licensing Agency

License Type	License Status	Expiration Date
	☐ Current ☐ Lapsed ☐ Inactive	

Has the applicant incurred and disciplinary proceedings in your State?
☐ No ☐ Yes (If yes, please attach **certified** copies of any actions.)

Are disciplinary proceedings pending?
☐ No ☐ Yes

Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended, or revoked?
☐ ***No*** ☐ ***Yes (If yes, please attach*** *certified* ***copies of any actions.)***

If applying for **MFR,** Did the applicant's training include the following:
☐ Spinal Immobilization, ☐ Epi Pen

If applying for **EMT**, Did the applicant's training include the following?
☐ Supraglottic airway (e.g., combitube, king), ☐ Epi Pen, ☐ Albuterol

If applying for **EMT Specialist (Intermediate 85)**, Did the applicant's training include the following (check the appropriate box(es)?
☐ IV Therapy (fluid replacement only) ☐ Endotracheal intubation ☐ Supraglottic airway

If applying for **Paramedic**, Did the applicant's training include (check the appropriate box(es)?
☐ IV Therapy ☐ Medication administration ☐ Endotracheal intubation ☐ Manual defibrillation

If this person is currently licensed as an EMT Specialist (Intermediate 85) or Paramedic, do they currently hold or have they held in the past, certification/licensure at the EMT level?
☐ No ☐ Yes

CERTIFICATION

I hereby certify that, to the best of my knowledge, the information above is true to the records of this Board.

_____ _____
Signature Date

_____ _____
Type or Print Name Title

_____ (S E A L)
Name of Licensing Agency

_____
Phone Number

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs know to this agency